HEALTH CHECK PROJECT BUDGET

Agency Name: _____ County Name:_____

Budget Period: ____(Mo.) ___ (Day), 20__ (Yr.) through June 30, 20__

CATEGORIES and LINE ITEMS	DMA BUDGETED AMOUNTS	IN-KIND CONTRIBUTIONS
PERSONNEL		
Health Check Coordinator 1 - Salary		
Fringe Benefits (HCC)		
FTE %:		
Health Check Coordinator 2 - Salary		
Fringe Benefits (HCC)		
FTE %:		
Health Check Coordinator 3 - Salary		
Fringe Benefits (HCC)		
FTE %:		
HCC Supervisor - Salary		
Fringe Benefits (Supervisor)		
FTE %:		
CONSULTANT & CONTRACT SERVICES		
EQUIPMENT	**Leave Blank**	**Leave Blank**
Computer		
SUPPLIES		
TRAVEL	**Leave Blank**	**Leave Blank**
Mileage		
Hotel		
Subsistence		
OTHER	**Leave Blank**	**Leave Blank**
AINS Data Processing Fee		
Continuing Education/Training		
Phone		
Postage		
Educational Materials		
Incentives		
Advertising		
Printing		
Office Space		
Administrative Fee/Overhead		
TOTAL		

Agency Director's Signature: _____

State Office Use only
Approved by: _____
Date:_____